Coastal Spine and Rehab Center

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Acknowledgement of Services

I, _____, hereby acknowledge that I am receiving (or I am about to receive) health care services at **Coastal Spine and Rehabilitation Center LLC**. I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds **or** out of the settlement of a liability claim.

I understand and agree to pay for my services rendered on a current basis if it is determined that:

1) ***there is no insurance company obligated to pay for these services...***
2) ***the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor...***
3) ***a liability claim exists, but my attorney refuses to agree to protect the interest of the doctor...***
4) ***I have not engaged the services of an attorney...***

Also, I understand and agree to pay my bill in full as soon as my Insurance denies my claim**,** my liability claim is settled or within three months of my last treatment, whichever occurs first.

Dated the _____ day of _____, _____
(day of month) (month) (year)

_____ _____
(patient/insured signature) (witness)

Insurance Assignment

In consideration of services to be rendered, I hereby assign and transfer to **Coastal Spine and Rehabilitation Center** any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical or PIP (Personal Injury Protection) for the payment of such services rendered. I agree to cooperate, aid and assist **Coastal Spine and Rehabilitation Center** in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I further assign and transfer to **Coastal Spine and Rehabilitation Center** an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of treatment. This assignment includes insurance benefits occurring to me under uninsured motorist coverage.

If a Medicare patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made in by behalf.

_____ _____
(patient/insured signature) (date)